EXHIBIT B

Consent for the Treatment of Chronic Babesiosis

Please discuss any questions with Dr. Lindner before initialing each statement and signing.

SW I am seeing Dr. Lindner for the diagnosis and treatment of Babesiosis. I do not hold him responsible to diagnose or treat other diseases or to provide acute or preventative medical care. I will consult my primary care provider (PCP) or specialists for such services.

SW I understand that Chronic Babesiosis is not yet recognized by the Centers for Disease Control (CDC) or the Infectious Diseases Society of America (IDSA) and that Dr. Lindner's practice is based upon his own interpretation of the human and veterinary literature and upon patients' responses to therapy.

SW I understand that this infection (usually caused by *Babesia odocoilei*, is often not detectable by commercially available tests. Diagnosis is based upon clinical judgment and response to treatment.

SW I understand that the treatment of this infestation is very difficult, requiring many months or years of multiple prescription medications and non-prescription supplements. My condition will worsen before it improves. If I do not continue the therapy I may be left in a worse state.

SW I understand that Dr. Lindner will prescribe some medications that are not FDA-approved for this infection, and/or at doses and durations that are not FDA-approved for any indication.

SW I understand that, without insurance coverage, the out-of-pocket cost for the most effective doses of all necessary medications and supplements will be approx. $1200/month. If insurance covers all prescription medications, the cost will be approx. $500/month.

SW I understand that there are risks and possible complications involved in attempting to eliminate this parasite: increased inflammation and suffering, fever, hemolysis, headaches, nausea, anxiety, depression, suicidality, derealization, impaired cognition, rashes, enlargement of the spleen, and cardiac rhythm disturbances. If I have any severe psychiatric or physical symptoms, I will see my PCP or go to an emergency room.

SW I agree to report my responses to treatment, including adverse effects, to Dr. Lindner as requested, and will submit to periodic blood tests to monitor my health as requested.

SW I understand that Dr. Lindner may recommend corticosteroid/DHEA therapy to control immune-mediated inflammation and allow me to tolerate therapy. I may require doses that cause fluid retention, muscle loss, bone density loss, high blood sugar and high blood pressure.

SW I hereby consent to the administration of antimicrobials, medications and supplements by Dr. Lindner for the purpose of reducing and hopefully eliminating parasites, improving my quality of life, and maintaining my health as well as possible in the process.

Stacey Wolking Date 10/16/21

230 West Tioga Street, Suite 5, Tunkhannock, PA 18657
Tel.: 570-955-3495 Fax: 570-836-7979 Info@hormonerestoration.com